STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004058	A. BUILDING: _____ B. WING _____	C 03/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADARNA HOME HEALTH CARE SERVICES INC	1400 EAST JOLIET STREET CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a state home health complaint investigation. Complaint: IN 00125513 - Substantiated: No deficiencies related to the allegation are cited. Facility #: 004058. Survey Dates: 3/25/13. Medicaid Vendor #: 200473790. Surveyor: Janet Brandt, RN, PHS. Adarna Home Health Care Services is in compliance with 410 IAC 17-9-5 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN March 27, 2013	N 000		